MDR: M4-02-2472-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

## I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 11/02/01.
   b. The request was received on 02/21/02.

## II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60
   b. HCFAs-1500
   c. TWCC 62 forms
   d. EOBs from other insurance carriers
   e. Medical documentation
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Response to Request for Medical Dispute Resolution
   b. HCFAs-1500
   c. TWCC 62 forms
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 06/20/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 06/24/02. The response from the insurance carrier was received in the Division on 07/08/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

## III. PARTIES' POSITIONS

1. Requestor: Request for Medical Dispute on the Table of Disputed Services
   "We obtained Pre-authorization [sic] for this equipment, which IS [sic] Medically Necessary for for proper Bone [sic] fusion due to compensable body Injury [sic] Sustained [sic] by the patient. We have resubmitted this claim with a prescription and A Letter of Medical Necessity Signed [sic] by the treating Doctor [sic] and Still [sic] were Not [sic] reimbursed at the full billed amount. We are now requesting."

2. Respondent: Letter dated 07/08/02
"It appears that the Provider seeks additional reimbursement for a bone growth stimulator…. It is the Respondent's position that the Requestor has not justified its costs in this matter. Requestor has failed to show the basis for the charges for the durable medical equipment… Requestor has failed to give its rate of return and has failed to provide any documentation of all the payments it has requested and accepted for this medical equipment…. The Requestor is only entitled to reimbursement that is fair and reasonable."

## IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 11/02/01.

2. The carrier denied the billed charges by denial codes, "M – NO MAR, REDUCED TO FAIR AND REASONABLE".
"D – DENIAL AFTER RECONSIDERATION".
"RE-EVALUATION NO ADDITIONAL RECOMMENDED ALLOWANCE PER INVOICE ON FILE".

3. Per the provider's TWCC 60, the amount billed is $5,000.00; The amount paid is $3,937.88; The amount in dispute is $1,062.12.

4. The provider submitted a letter of preauthorization dated 11/01/01 for the purchase of the bone stimulator.

5. The following table identifies the disputed services and Medical Review Division's rationale:

| DOS | CPT or Revenue CODE | BILLED | PAID | EOB Denial Code(s) | MAR$ | REFERENCE | RATIONALE: |
|---|---|---|---|---|---|---|---|
| 11/02/01 | E0748 | $5,000.00 | $3,937.88 | M | DOP | Rule 133.307 (g) (3) (E);<br>CPT descriptor | The provider failed to meet the criteria of 133.307 which states, "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title…" As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. The provider did submit EOBs from other insurance carriers, but the EOBs submitted from other carriers were not redacted. The EOBs proved to be insufficient to meet the criteria of Rule 133.307 (g) (3) (E).<br><br>**No** additional reimbursement is recommended. |
| **Totals** | | $5,000.00 | $3,937.88 | | | | The Requestor **is not** entitled to additional reimbursement. |

The above Findings and Decision are hereby issued this 30th day of January 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm